WRITTEN TESTIMONY TO THE TEXAS HOUSE OF REPRESENTATIVES COMMITTEE ON PUBLIC HEALTH – Interim Charge #2
(Submitted per posting for October 5, 2020)

Submitted by Don McBeath, Director of Government Relations, Texas Organization of Rural & Community Hospitals (TORCH). TORCH is the trade association of the 157 rural hospitals across Texas.

Interim Charge 2: *Review how Texas is preparing for state and federal budgetary changes that impact the state's health programs, including: the Family First Prevention Services Act; the next phase of the 1115 Healthcare Transformation and Quality Improvement Program Waiver; Texas' Targeted Opioid Response Grant; the Centers for Medicare and Medicaid Services proposed Medicaid Fiscal Accountability Rule, and the Healthy Texas Women Section 1115 Demonstration Waiver.*

The focus of this written testimony is on Medicaid Supplemental Payments such as the 1115 Waiver and the proposed Medicaid Fiscal Accountability Rule (since withdrawn) and their impact on Texas' 157 rural hospitals.

Although rarely discussed or known about outside of hospital circles, Medicaid supplemental payments are a series of extra payment programs that have been implemented over the past few decades by the Centers for Medicare and Medicaid Services (CMS), which administers both Medicare and Medicaid. These payments are intended to help bridge the gap between Medicaid patient services payments and what Medicare would have paid for the same service, as well as help hospitals and other providers with losses incurred by growing levels of uninsured and other shortfalls.

For Texas, the various supplemental payments programs pump an estimated $10+ billion a year back into hospitals (federal and local state matching dollars combined). These programs include the 1115 waiver, Disproportionate Share Hospital, Uniform Hospital Rate Improvement Program, and nursing home Quality Incentive Payment Program. Over time, these supplemental programs have been become such a critical revenue stream for hospitals that if abolished or greatly reduced without replacement dollars many hospitals would close. Most Texas rural hospitals report between 10% and 30% of their operating cost is covered by supplemental payments.

It is important to note that as Medicaid is a jointly funded federal and state program, the supplemental Medicaid payments also require state matching dollars. As these programs were launched, many states including Texas chose not to increase their state budgets to produce the state matching dollars and instead deferred to local units of government – mostly hospital districts – to provide the matching dollars. That leaves the Legislature somewhat distanced from the programs and the dollars out of the state budget, although the Texas Health and Human Services Commission (HHSC) operates these programs at the state level. It is vitally important that members of the Legislature stay informed about the programs and strongly encourage the Texas Health and Human Services Commission to continue to work with CMS to maximize and continue these programs for Texas hospitals and health providers.

Because of escalating cost associated with these programs, the federal government has from time to time tried to restrict or reduce them, which would only add pressure to the Texas state budget. It has also become clear that these programs and payments are vulnerable and long-term stability is in question. A major threat to continuation of the supplemental payment programs arose as recently as last November when CMS proposed a major rule change for the programs known as the Medicaid Fiscal Accountability Regulation (MFAR). It was branded by CMS as an effort to enhance transparency and

provide more detail on how hospitals and other providers spend the money they receive from supplemental payments. Hospitals were supportive of efforts to enhance transparency in the spending of taxpayer dollars. But, in reality, the 64-page proposed regulation was less about transparency and more about questioning the state matching dollar methodologies utilized by Texas and some other states (although CMS had historically approved the method Texas uses). The proposed rule would have put pressure on the Texas Legislature to either expand Medicaid, add the matching dollar cost to the state budget, or watch the programs disappear and many hospitals close.

As one would expect, the hospital industry rallied against the proposed rule as well as state leaders and even members of Congress. We appreciate engagement from state leadership regarding economic impact and consequences for Texas.

Fortunately for Texas and other states, the CMS administrator announced on September 14 that the proposed rule would be withdrawn. Even with the proposed MFAR rule off the table, questions linger about continuation of the supplemental programs from policy and financial perspectives. There are also fears among hospitals that CMS could, as a condition of future waivers rather than in a general rule, continue to question how Texas provides matching dollars.

As to the actual supplemental payment programs, the 1115 waiver which Texas is currently under is the most widely known. There are two components to the 1115 waiver. One part, known as Uncompensated Care (UC), helps cover some of the cost of uninsured patients. The other part, known as the Delivery System Reform Incentive Payment (DSRIP), funds innovative approaches to providing care for Medicaid patients. There is one year left to the current five-year waiver. Over the first 4 years CMS directed a decline each year in payments to cover the UC section with increases in DSRIP. But now CMS also seems to be questioning the sustainability of the innovation programs. A big question is will CMS grant Texas another waiver. And, if they do what about the DSRIP programs? Rural hospitals have used DSRIP dollars to serve vulnerable, uninsured populations and critical health care access in rural Texas which is threatened without them.

Another looming issue is the data that CMS requires to support the expense of dollars in the current waiver. It is cumbersome, complex, and confusing. Some hospitals meet the intent of their special programs but the data may be off target. Plus, with COVID19 many hospitals are behind in tracking the appropriate data. In fact, hospitals have asked HHSC to submit a request to CMS for a one-year extension to submit supporting data before they demand return of dollars for lack of data.

Certainly, questions remain as to whether CMS will grant Texas another waiver when this one expires or what terms and conditions they may next insist upon in a future waiver. Hopes are that another waiver would be approved but that is currently an unknown. It is not clear to hospitals where HHSC is on seeking some type of replacement waiver. We view rural priorities in any replacement plan to be telehealth, maternal and child heath, and primary care and support creation of direct payment program for rural hospitals and clinics/physicians.

While there are many unknowns and questions, it is important for this committee and the Legislature as a whole to be aware of both the importance of these programs to our state's health care system and the vulnerability we are facing.

Some detail of the FY 19 Medicaid supplemental estimated payments by HHSC is below.

Thank you for your review of this matter and for your consideration in supporting the future of rural Texas.

Don McBeath
Director of Government Relations
Texas Organization of Rural & Community Hospitals (TORCH)

TEXAS MEDICAID SUPPLEMENTAL PAYMENTS PROJECTED FOR FY19[1]

PROGRAM	TOTAL PAYMENTS[2]	RURAL HOSPITALS ONLY
1115 UC	3.1 B[3]	475 M (15.3%)
1115 DSRIP	3.1 B[3]	183 M (5.9%)
DSH	1.8 B	81 M (4.5%)
UHRIP	1.25 B	23 M (18.4%)
TOTAL	**9.25 B**	**762 M (8.2%)**
QIPP	650 M[4]	

[1] FY2019 projected payments are for FY2019 time period, however some payments will occur in FY2020.

[2] TOTAL PAYMENTS are projected and rounded by the Texas Health and Human Services Commission, and are subject to change. Dollars are all funds – combined federal (approx. 58.19 %) and local IGT (approx. 41.81 %).

[3] TOTAL PAYMENTS FOR UC are directed primarily to hospitals but approximately one-third of the TOTAL PAYMENTS for DSRIP are directed to non-hospital providers.

[4] QIPP provides supplemental Medicaid payments to nursing homes, however as some Texas rural hospital own nursing homes they receive benefit from this program.